

Easy Pay Program Consent

Date: _____

In an effort to make the necessary healthcare more immediately accessible for our patients our office offers patients the option to pay their deductibles over time if needed, through the Easy Pay program. By completing this consent, your high deductible will be broken down into smaller payments automatically charged to your credit card account until the charges have been settled. This eases the sudden burden of a high deductible which needs to be met. All credit card information is kept in strictest confidence, with only one office member having access to said information. As always, flex plan program benefit receipts are always available upon request.

I authorize the office of Dr. Scott Burdge to incrementally charge my credit card for the balance of charges not paid by my insurance within 90 days following treatment.

Not to exceed: \$50.00 \$100.00 or _____ per week _____ or month _____

I understand this form is valid for one year unless I cancel the authorization through written notice to this office.

Patient Name:		Signature:	
Cardholder Name: (if different)		Signautre:	
Billing Address:			
City:	State:	Zip:	
Card type (circle one): Visa Master Card American Express Discover			
Credit Card Number:			
Expiration Date:		CCV#:	